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FOR STATE
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02315

| | | | | | | | | | |
|---|--|---|---|--|--|--|------------------|---|------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements | | c. LENGTH OF STAY IN 1b Life | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | |
| | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Clements | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First William | Middle H. | Last Armstrong | 4. DATE OF DEATH Feb. 1, 1962 | Month Feb. | Day 1 | Year 1962 | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH June 7, 1961 | 9. AGE (In years last birthday) yrs. 7 | IF UNDER 1 YEAR Months 7 | Days 0 | IF UNDER 24 HRS. Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| | | | | Maryland | | U.S.A. | | | |
| 13. FATHER'S NAME Robert Armstrong | | 14. MOTHER'S MAIDEN NAME Margie Armstrong | | Address Clements, Maryland | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Margie Armstrong | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition | | DUE TO Malnutrition | | INTERVAL BETWEEN ONSET AND DEATH 2 days since birth | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Wm D Boyd | | | | | | | |
| EXAMINER'S NAME (Type) William D. Boyd M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | Address (Street, city, town, or county) Morganza, Maryland | | DATE SIGNED 2/5/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/3/62 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cemetery | | 22d. LOCATION (City, town, or country) (State) Morganza, Maryland | | | |
| 23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS 4100203182 | | 24a. REC'D BY REGISTRAR DATE FEB 7 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Faane | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 7
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

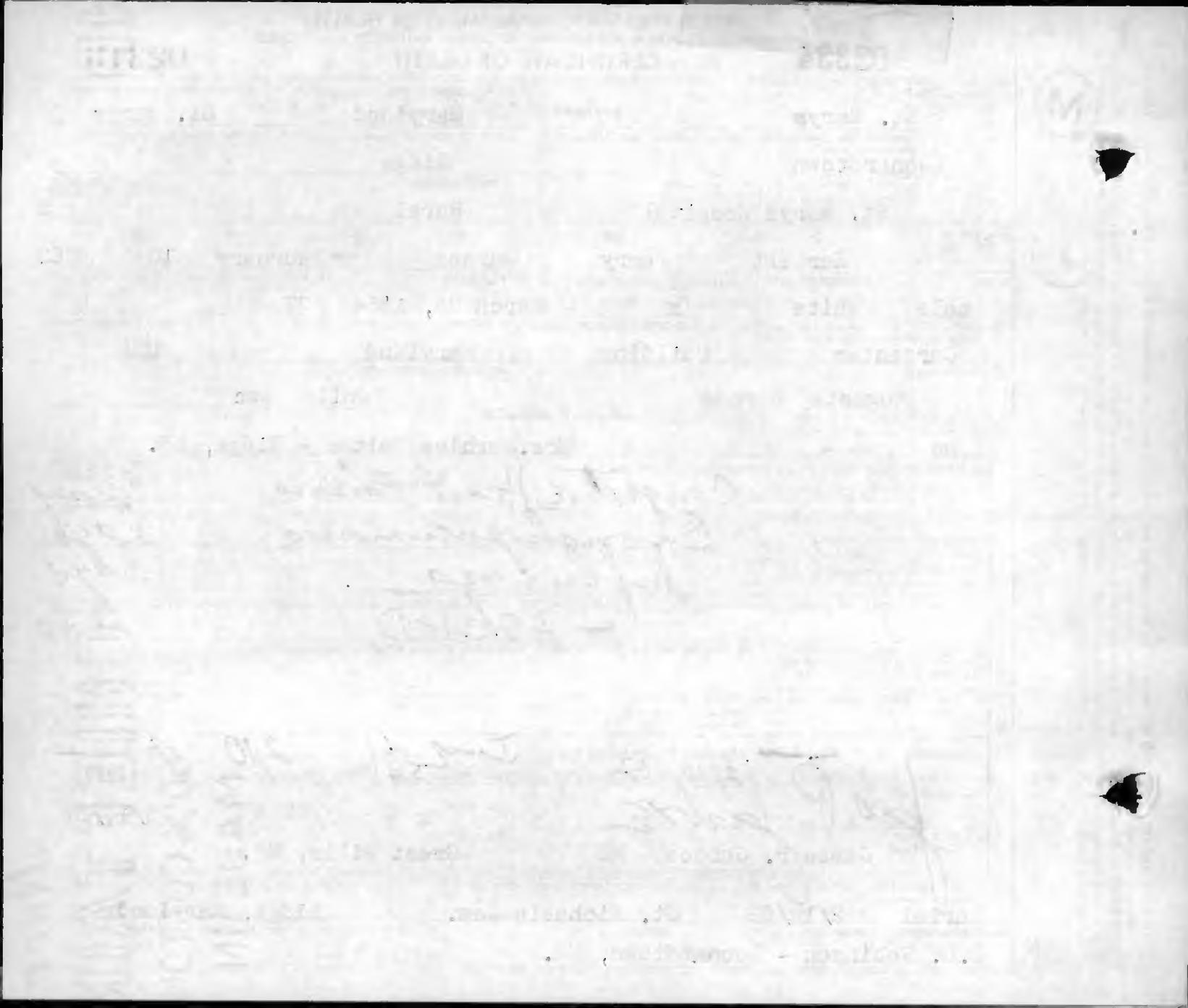
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02334

CERTIFICATE OF DEATH

02316

| | | | | | |
|---|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Marys | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ridge | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital | | | d. STREET ADDRESS Rural | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First Herbert | Middle Perry | Last Barnes | 4. DATE OF DEATH Month February | Day Year 10 19 62 |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH March 23, 1884 | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Building | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Augusta Barnes | | | 14. MOTHER'S MAIDEN NAME Julia Dean | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Berhice Talton - Ridge, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 480 X DUE TO 1 day Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchopneumonia days (c) Influenza days | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? HASKED YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Doy at work <input type="checkbox"/> at work <input type="checkbox"/> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January 1962 to 2/10 1962 , that (I) (we) last saw the deceased alive on 2/10 1962 , and that death occurred at 5 AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE James P. Jarboe | | | M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 2/10/62 |
| 22c. PHYSICIAN'S NAME (Type) James P. Jarboe, MD | | | 22d. ADDRESS Great Mills, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/12/62 | 23c. NAME OF CEMETERY OR CREMATORIAL St. Michaels Cem. | | 23d. LOCATION (City, town, or county) (State) Ridge, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | | ADDRESS | 25a. REC'D BY REGISTRAR FEB 13 '62 | 25b. REGISTRAR'S SIGNATURE Catherine S. Krause |



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02335

CERTIFICATE OF DEATH

Item 11 Film G308 3/1/62 iwk

02318

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN lb

D O A

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

Eli

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

February 17, 1962

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

March 21, 1915

9. AGE (In years
last birthday) IF UNDER 1 YEAR
46 yrs. Months Days Hours Min.

e. IS RESIDENCE
ON A FARM?
YES NO

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farming

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Michigan

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Brubacher

Katie Gehmen

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

217-32-0188 Mrs Priscilla W. Brubacher Same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

30 min -

0
MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20e. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
White
at work Not White
at work

20e. PLACE OF INJURY (Home, firm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

19..... to 19.....

19..... to Feb. 17, 1962

21. I certify that (I) (this hospital) attended the deceased from.....
saw the deceased alive on.....

19....., and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE

W.H. Patrick

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

Feb. 18, 1962

22c. PHYSICIAN'S
NAME (Type)

William H. Patrick M. D.

22d. ADDRESS

Lexington Park, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

2/21/62

23c. NAME OF CEMETERY OR CREMATORIAL

Armish Cemetery

23d. LOCATION (City, town or county)

Loveville,

(State)

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATED FEB 23 '62

Arthur S. Kraus

1940.

January

1940.

1940.

1940.

1940.

February

1940.

1940.

1940.

March

1940.

1940.

1940.

1940.

1940.

1940.

1940.

1940.

1940.

1940.

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02319

Item 4 Film 6308 3/6/62 m

| | | | |
|--|--|---|-----------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | |
| a. COUNTY | | e. STATE | |
| St. Mary's | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 16 | |
| Rural Lovetville | | 15 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle |
| John | | F. | Brubacher |
| 4. DATE OF DEATH | | Month | Day |
| February 21, 1962 | | Month | Day |
| 5. SEX | | 6. COLOR OR RACE | |
| Male | | White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Jan. 5, 1941 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| Farming | | | |
| 10c. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Penns | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Enoch H. Brubacher | | Catherine S. Fox | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| No | | | |
| 17. INFORMANT | | Address | |
| Father same as # 2 above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) | | | |
| 830X DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) | | | |
| DUE TO | | | |
| (c) | | | |
| Crushing injury of chest | | | |
| INTERVAL BETWEEN ONSET AND DEATH immed | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | |
| 20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| Car fell off truck while deceased was underneath it. | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 2-24-62 | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm | |
| 20f. (City or town) | | (County) (State) | |
| Loveville St. Mary | | Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | |
| William D. Boyd M.D. | | | |
| Address (Street, city, town, or county) | | | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) | | 22f. DATE THEREOF | |
| Burial | | 2/28/62 | |
| 22g. NAME OF CEMETERY OR CREMATORIAL ADDRESS | | 22h. LOCATION (City, town, or country) (State) | |
| Amish Cemetery | | Loveville, Maryland | |
| 24e. REC'D BY REGISTRAR | | | |
| 24f. REGISTRAR'S SIGNATURE | | | |
| DATE MAR 2 '62 | | | |
| Other S. Kline | | | |
| VS. A15ME 5M 7/59 | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02337

CERTIFICATE OF DEATH

02320

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Valley Lee Rural

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

X Rural Valley Lee

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES

XX

NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
February
6, 1962

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

August 19, 1901

9. AGE (In years
last birthday)
60 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country)
Maryland12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

George R. Watts

14. MOTHER'S MAIDEN NAME

Rosette Greenwell

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

220-32-5744

Mrs James Bean

Valley Lee, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

420.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Ventricular Fibrillation
Myocardial Infarction
H.A.S.C.V.DINTERVAL BETWEEN
ONSET AND DEATH

min.

min.

yes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

19

21. I certify that (I) (this hospital) attended the deceased from May 19, 1961, to May 21, 1962, that (I) () last saw the deceased alive on May 19, 1962, and that death occurred at 3:45 PM, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

J. Patrick Jarboe M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
27/7/62

Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

2/9/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

St. George Cemetery

23d. LOCATION (City, town or county)

(State)

Valley Lee,

Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR

DATE FEB 13 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

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VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1

MARYLAND

02338

CERTIFICATE OF DEATH

02321

1. PLACE OF DEATH
a. COUNTY

St. Mary's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

MARYLAND

c. LENGTH OF STAY IN lb

5 hrs

3. NAME OF
DECEASED
(Type or print)

Benedict

Drury

Duke

5. SEX

Male

White

WIDOWED

D.VORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Sept. 3, 1918

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Broker & Realtor

13. FATHER'S NAME

Roland Benjamin Duke

14. MOTHER'S MAIDEN NAME

Maryland

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

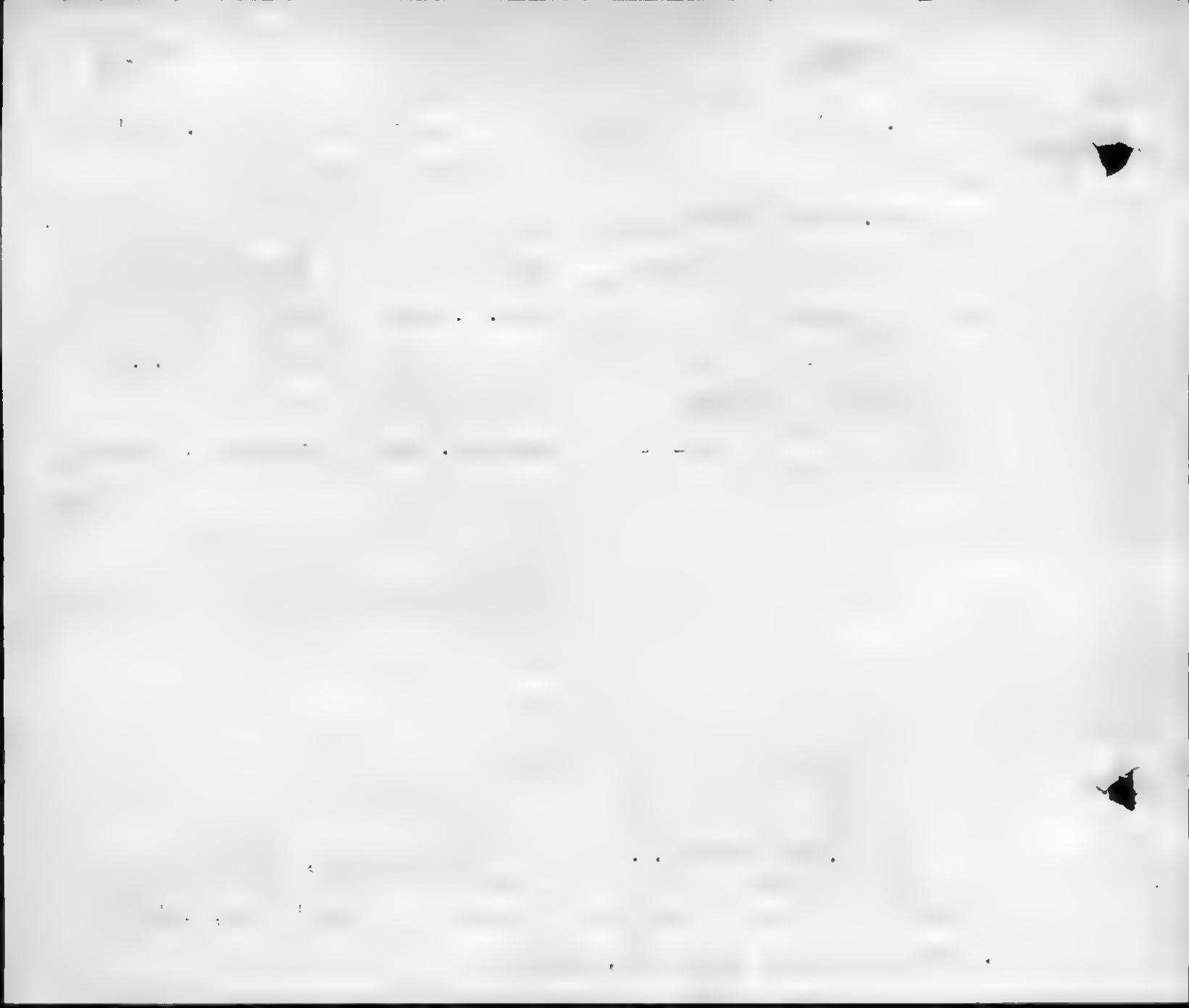
No

218-12-0696 Virginia B. Duke

Address

Leonardtown, Maryland

(Yes, no, or unknown) If yes give war or date of service



FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02322

1. PLACE OF DEATH
a. COUNTY

St. Mary's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Great Mills,

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Item 3 Form G507

& 17

MARYLAND

c. LENGTH OF STAY IN 1b

20 years

2/14/62 Inv

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE Maryland

b. COUNTY St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

d. STREET ADDRESS

Great Mills

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Agnes

Elmer Edison

DATE
OF
DEATH

Month Dey Year

February 1, 1962

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

Colored

WIDOWED DIVORCED

Nov 25, 1903

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Home

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Edison

Address

George Edgerton

Great Mills, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Broncho-pneumonia, lower lobes, bilateral

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
give rise to immediate cause

(a), stating the underlying
cause last.

(b)

DUE TO

(c)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

February 2, 1962

(State)

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

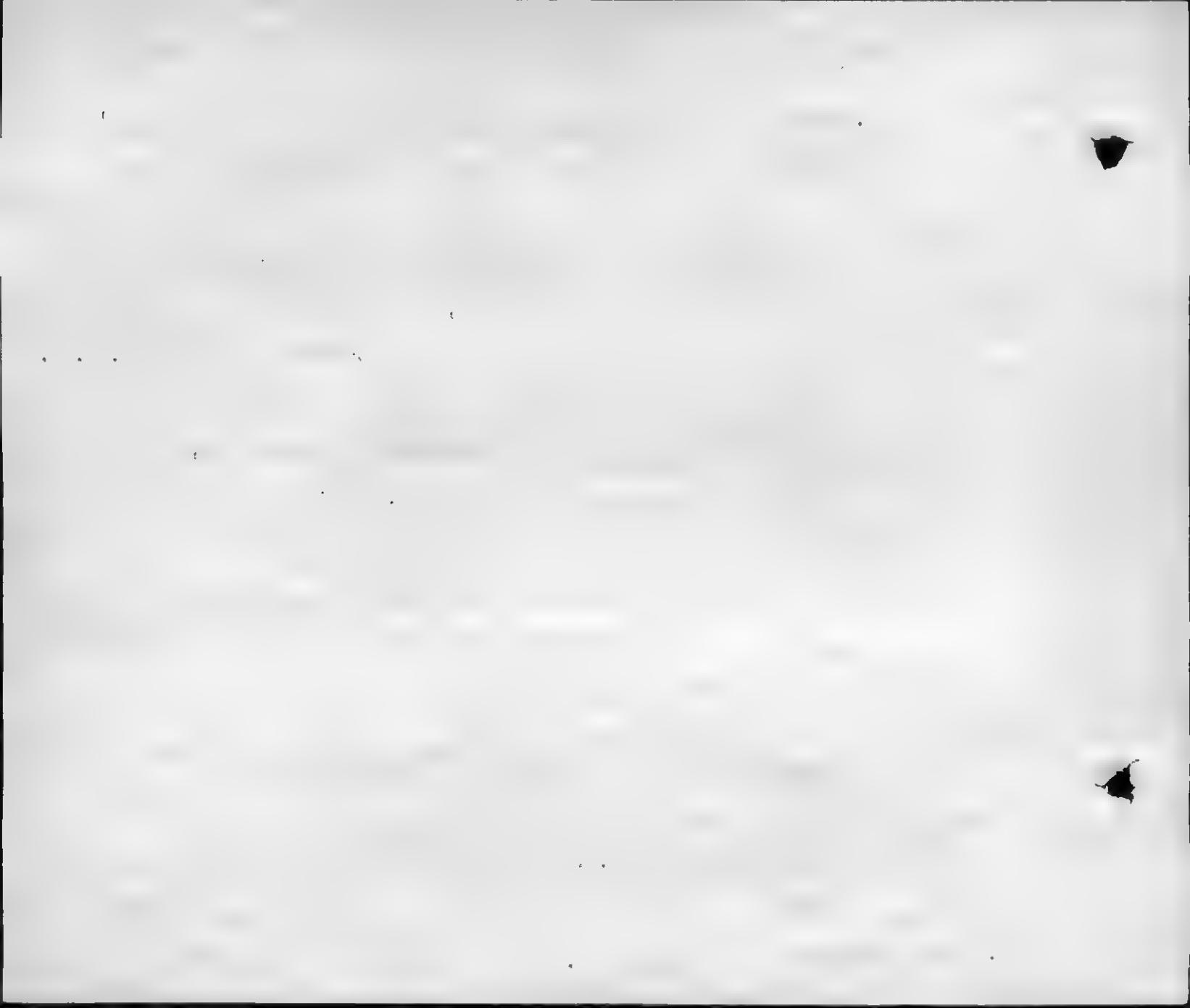
DATE FEB 7 '62

Arthur L. Krause

VS. AIMEE
5M 7/59

23. FUNERAL DIRECTOR

ADDRESS
W. Clarke Mattingley Leonardtown, Md.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pandemic" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02323

1. PLACE OF DEATH
a. COUNTY

St. Mary's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Piney Point

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN 16

Life

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Feb. 24, 1962

IF UNDER 1 YEAR
Months Days Hours Min.

5. SEX

6. COLOR OR RACE

Male

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

Feb. 5, 1962

9. AGE (In years
last birthday)

yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

None

13. FATHER'S NAME

George E. Goddard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

14. MOTHER'S MAIDEN NAME

Ethel G. Adams

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

7630
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Mother same as # a above

Bronchial pneumonia

INTERVAL BETWEEN
ONSET AND DEATH
1 week

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I e.g. 19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE

William D. Boyd M.D.

Address (Street, city, town, or county)

2/24/62
(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

22b. DATE THEREOF
2/25/62

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

St. George Cemetery

Valley Lee, Maryland

23. FUNERAL DIRECTOR

ADDRESS

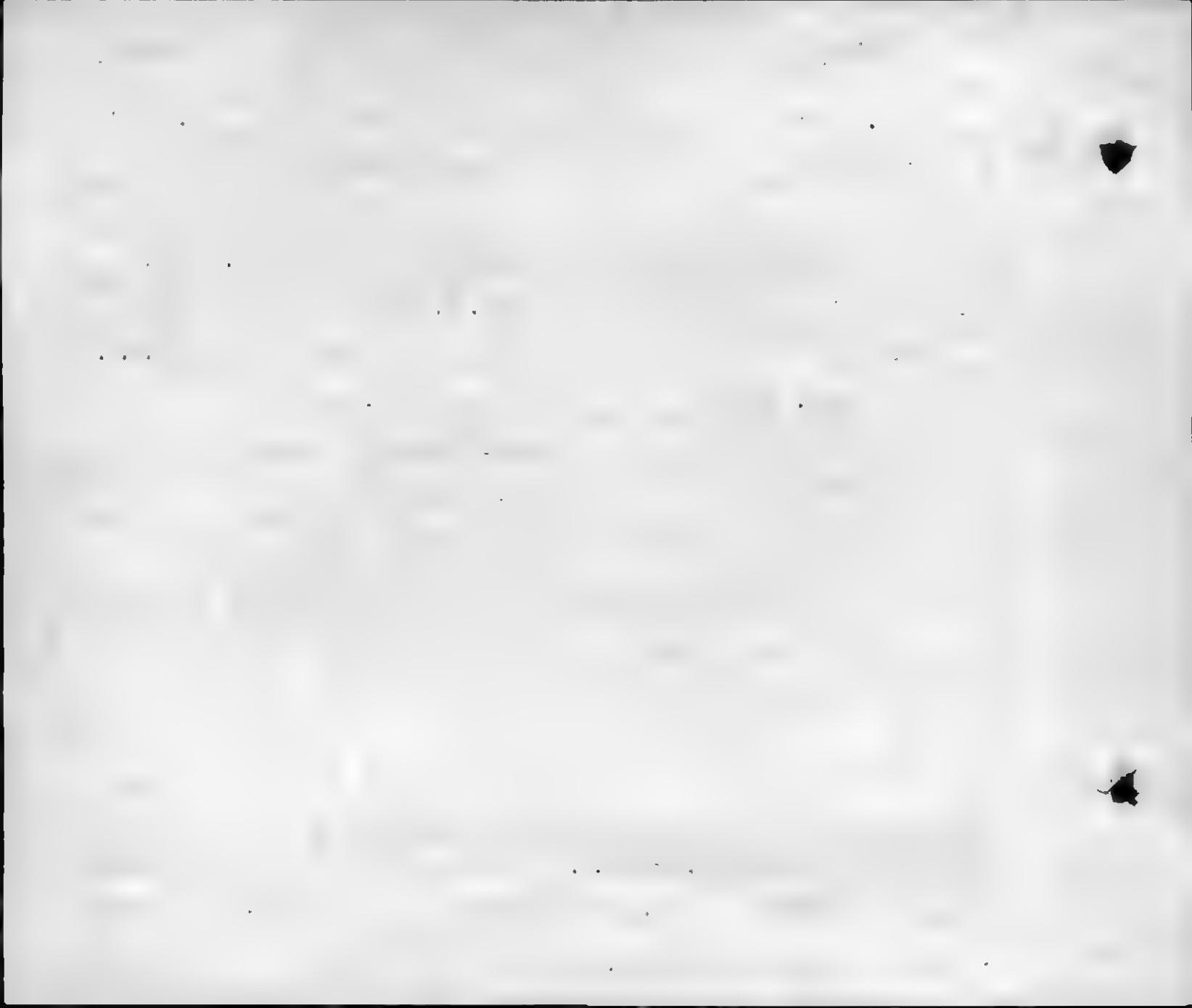
24e. REC'D BY REGISTRAR

FEB 27 '62
DATE

24b. REGISTRAR'S SIGNATURE

Charles L. Kraus

W. Clarke Mattingley Leonardtown, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02341

CERTIFICATE OF DEATH

02324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

St. Mary's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Clements

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

52 years

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Abell

Guy

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

Sept. 7, 1887

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife & Merchant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Maryland

U. S. A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Perry Abell

14. MOTHER'S MAIDEN NAME

Sarah Fulton

Address

Mrs Claudia Yates

Clements, Maryland

INTERVAL BETWEEN
ONSET AND DEATH
8 months

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Carcinoma Head of Pancreas

DUE TO

(b)

DUE TO

(c)

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part I of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Feb 17, 1962 that (I) () last saw the deceased alive on Feb 17, 1962 and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE

W.H. Patrick M.D.MD ATTENDING PHYS.
 DIRECTOR STAFF PHYS.
22d ADDRESS22b. DATE SIGNED
2-18-62

22c. PHYSICIAN'S NAME (Type)

William H. Patrick M. D.

Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial Feb. 20, 1962

23c. NAME OF CEMETERY OR CREMATORIUM

St. Josephs Cemetery

23d. LOCATION (City, town or county)

(State)

Morganza,

Maryland

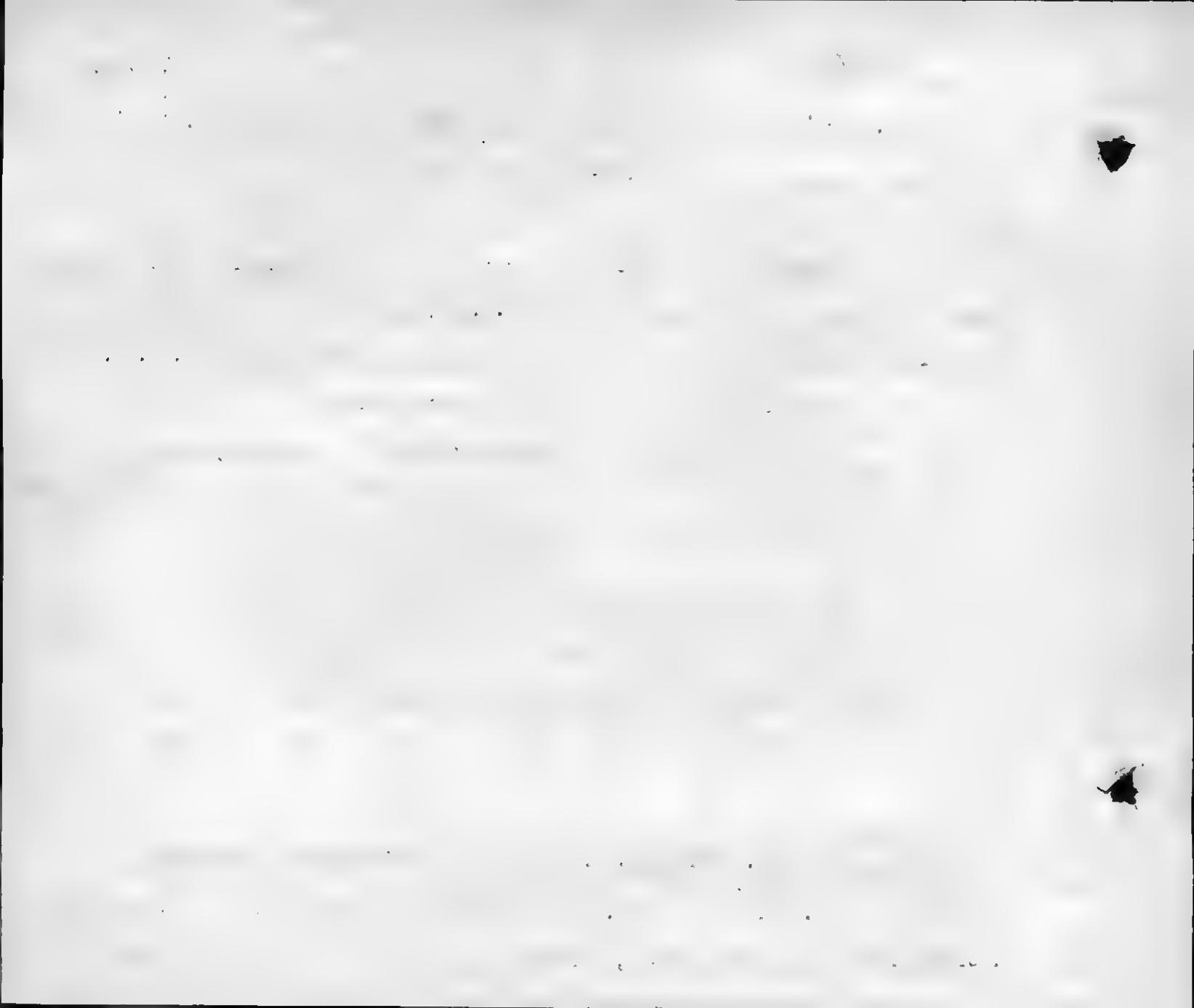
24. FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE FEB 23 '62

S. J. S. Times



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

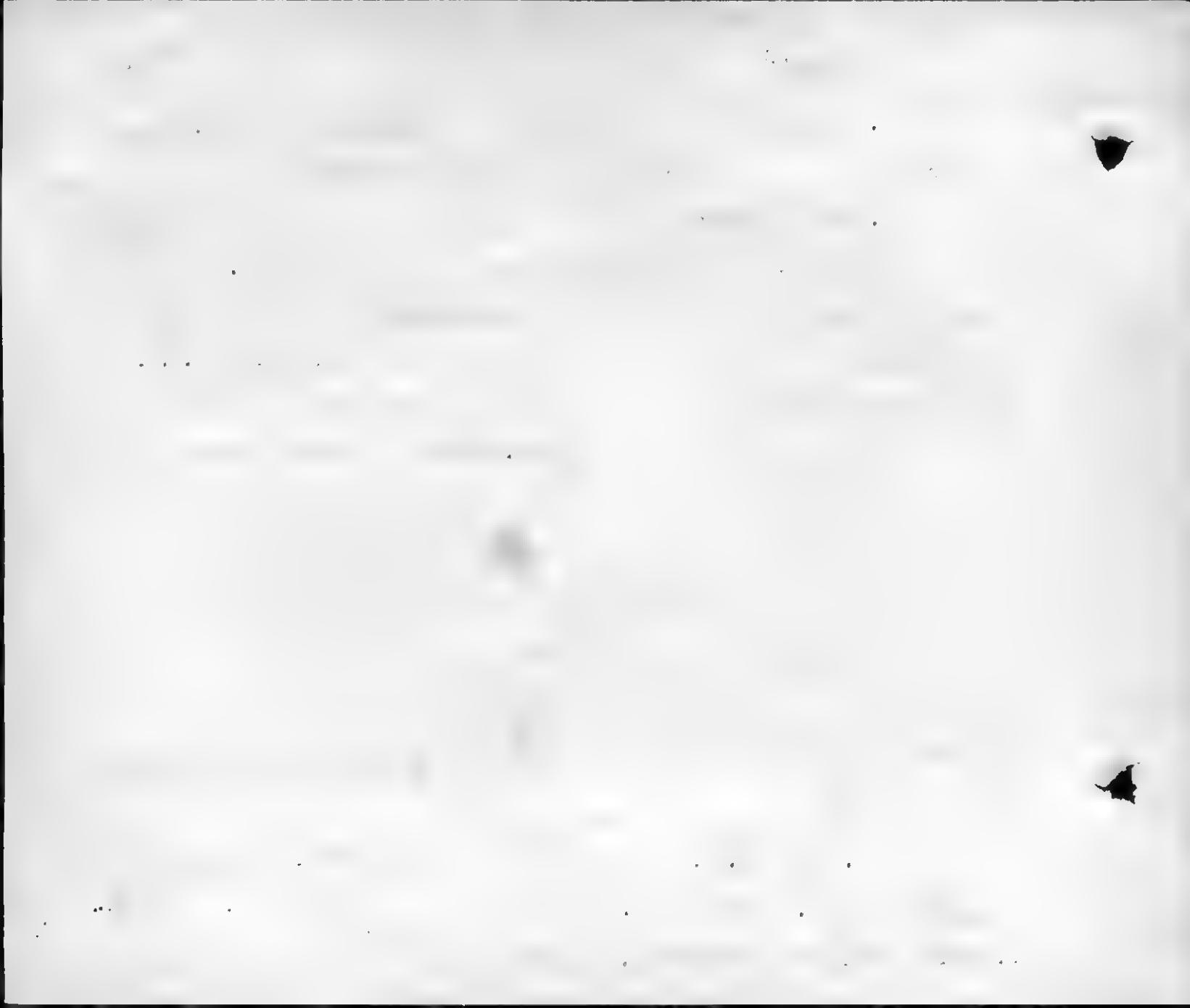
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02342

CERTIFICATE OF DEATH

02325

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb 9 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | X Rural Avenue d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Spencer | First: Ignatius Middle: Hayden Last: | 4. DATE OF DEATH Feb. 23, 1962 | Month Day Year Feb. 23, 1962 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 27, 1886 | 9. AGE (In years last birthday) 75 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 13. FATHER'S NAME William Abell Hayden | | 14. MOTHER'S MAIDEN NAME Selina Downs | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Ann W. Hayden | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | Address Avenue, Maryland | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO (b) Ruptured aortic aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH Fractured right hip. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g.) Fractured right hip. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter return of injury in Part I or Part II of item 18.) Fractured right hip. | |
| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | (County) | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/18 to 2/23 , 1962, that (I) (we) last saw the deceased alive on 2/23 , 1962, and that death occurred at 8:00 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED 2/23/62 | |
| 22c. SIGNATURE A. Samadi M. D. | | ATTENDING PHYS. <input type="checkbox"/> M.D. | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius | |
| 23b. DATE THEREOF Feb. 26, 1962 | | 23d. LOCATION (City, town or county) Leonardtown, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | 25a. REC'D BY REGISTRAR DATE MAR 5 '62 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02326

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my stay is necessary, please write the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

M

| | | | | | |
|--|------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall | | c. LENGTH OF STAY IN lb Life | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Park Hall | | | |
| 3. NAME OF DECEASED (Type or print) First Andrew Middle Jackson Last Hill | | 4. DATE OF DEATH Month February Day 24 , Year 19 62 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Oct. 9, 1884 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Harrison Hill | | 14. MOTHER'S MAIDEN NAME Louise ?? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | | | |
| 17. INFORMANT Mrs Julia D. Courtney RFB 343 Lexington Park, | | Address Maryland 27 Dec, 3 months | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CV accident | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA of stomach | | | | | |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <i>- 14-24-13 Boyd 73</i> DATE SIGNED 2/24/62 | | | | | |
| EXAMINER'S NAME (Type) William D. Boyd M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/27/62 | 22c. NAME OF CEMETERY OR CREMATORIUM Zion Church Cemetery | 22d. LOCATION (City, town, or county) Lexington Park, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | | ADDRESS | 24a. REC'D BY REGISTRAR DATE FEB 27 '62 | 24b. REGISTRAR'S SIGNATURE <i>Clarke</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02327

02344

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION St. Marys Hospital | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) | | e. STREET ADDRESS Rural | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) SUSAN ANGELINE HILL | | 4. DATE OF DEATH Month Day Year February 24 1962 | |
| 5. SEX female | | 6. COLOR OR RACE white | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 28, 1883 | |
| 9. AGE (in years last birthday) 78 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. US LAB OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 10c. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George G. Hill | | 14. MOTHER'S MAIDEN NAME Lucy Cullison | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Mrs. Alma Ellis - Oakley, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a) Fractured hip - fall | |
| 19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) J | | 20f. (City or town) (County) (State) 1962 Feb 24, 1962, (Ia) (I) (we) last | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 27, 1962, to Feb 24, 1962, (Ia) (I) (we) last saw the deceased alive on Feb 27, 1962, and that death occurred at M. from the causes and on the date stated above | | 22a. SIGNATURE J. Roy Guyther | |
| 22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, MD | | 22d. ADDRESS M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> Mechanicsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/27/62 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cem. | | 23d. LOCATION (City, town, or county) Bushwood, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. Robinson | | 25a. ADDRESS P.B. Robinson - Leonardtown, Md. | |
| 25b. REGISTRAR'S SIGNATURE L. May S. Holmes | | 25c. DATE FEB 24 '62 | |



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02345

CERTIFICATE OF DEATH

02328

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN lb

6 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

Vernette

Middle

Last

4. SEX

6. COLOR OR RACE

Female

Colored

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

Johnson

B. DATE OF BIRTH

May 4, 1911

4. DATE
OF
DEATH

February 19,

19 62

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Country & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Jones

14. MOTHER'S MAIDEN NAME

Ebbie Brown

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Charles N. Johnson Piney Point, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

151X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

DUE TO

(c)

Caranosis of stomach

INTERVAL BETWEEN
ONSET AND DEATH

1 year (?)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia. 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb 18, 1962 to Feb 19, 1962 that (I) (we) last saw the deceased alive on Feb 18, 1962, and that death occurred at 2:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

P. J. Bean M. D.

M.D.

ATTENDING
PHYS.

MED
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
2/10/62

22c. PHYSICIAN'S
NAME (Type)

P. J. Bean M. D.

22d. ADDRESS

Great Mills, Maryland

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

2/22/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

St. Mark's Cemetery

23d. LOCATION (City, town or county)

Valley Lee, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley Leonardtown, Maryland

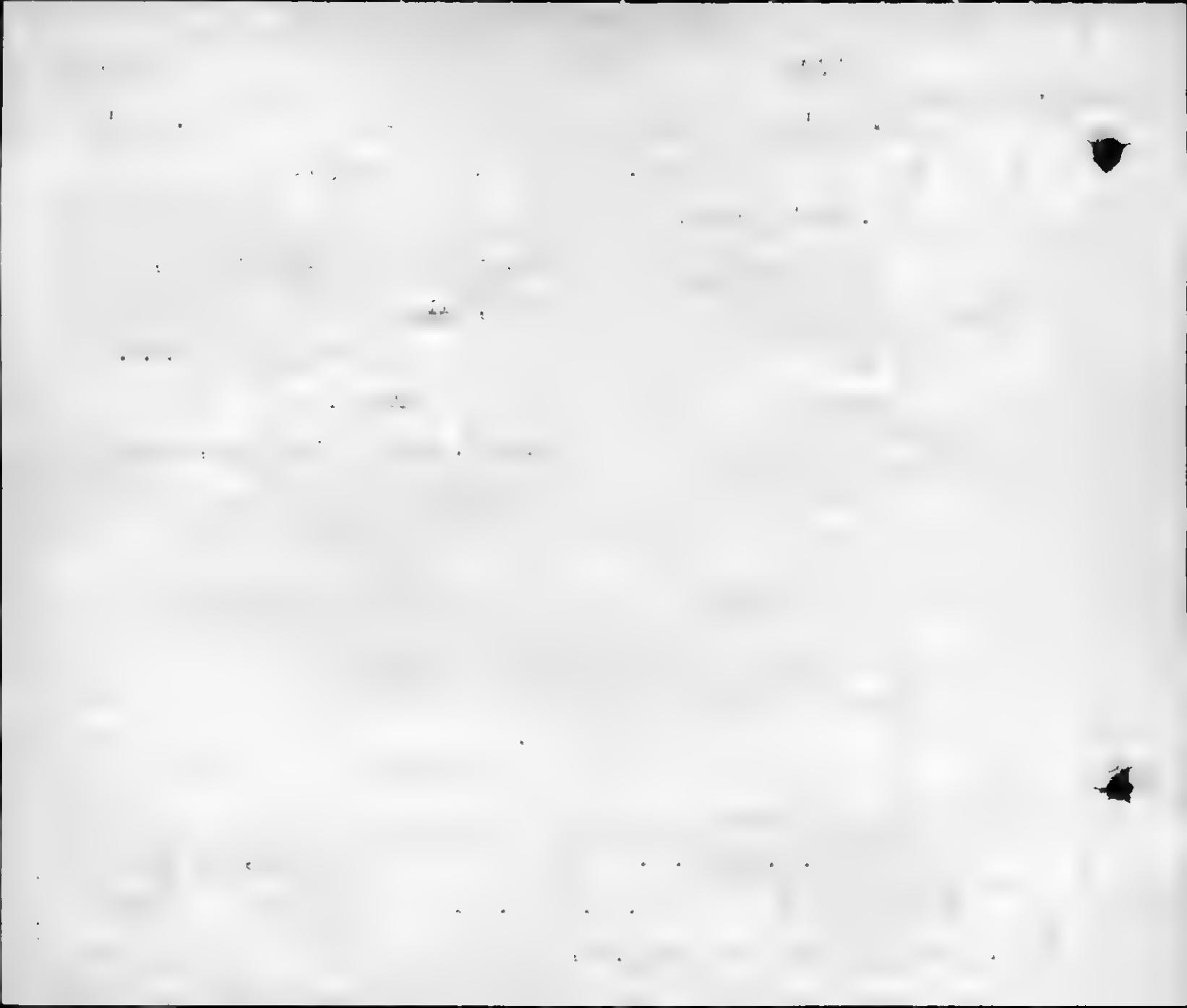
ADDRESS

25a. REC'D BY REGISTRAR

FEB 26 '62

25b. REGISTRAR'S SIGNATURE

W. S. Moore



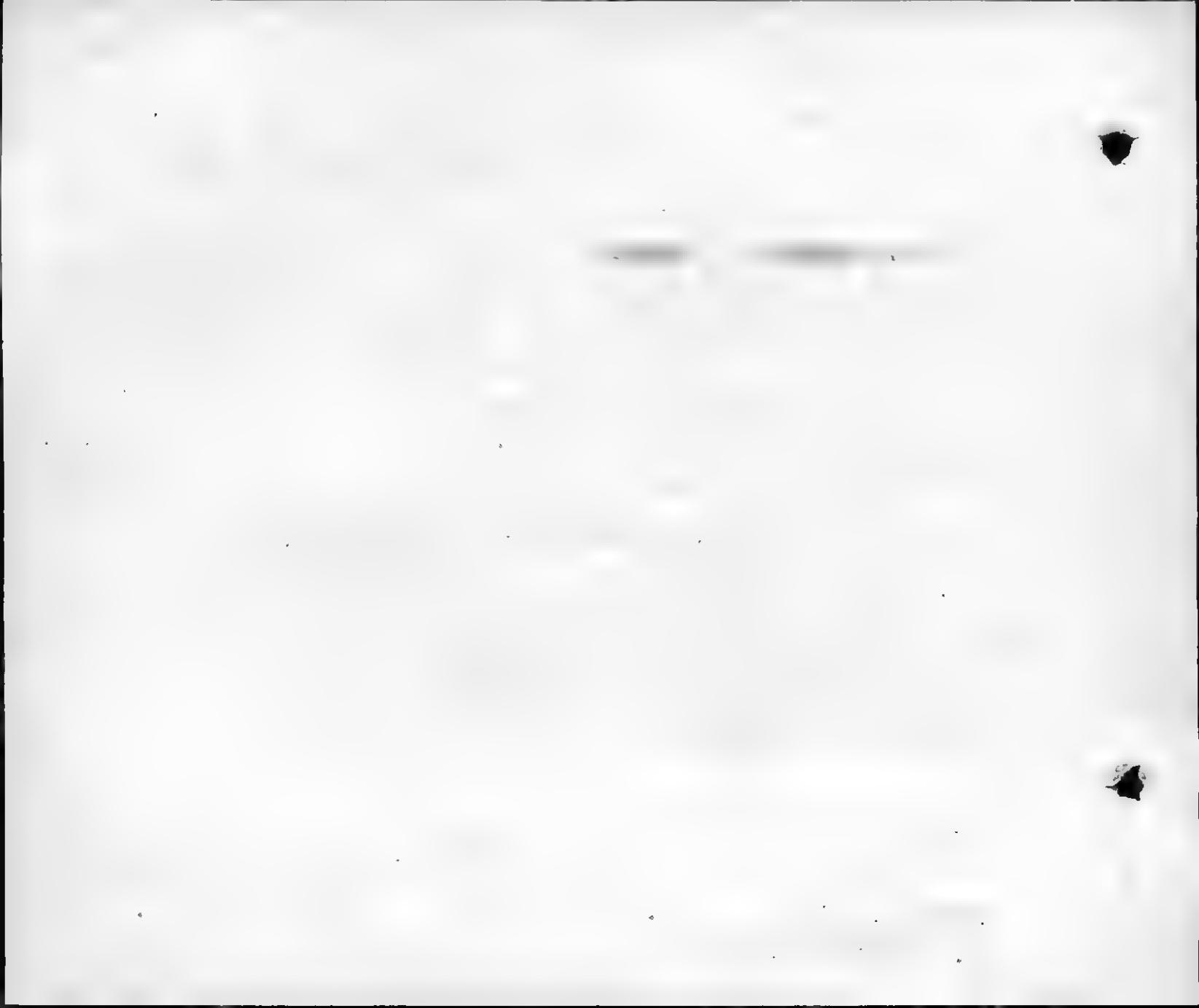
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

02346

02329

| | | | | | | | |
|---|----------------------------------|---|--|--|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital | | d. STREET ADDRESS Rural | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) EMMAH [REDACTED] GRACE [REDACTED] | First | Middle | Last | 4. DATE OF DEATH KNIGHT | Month | Day | Year February 25 1962 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15, 1881 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days | Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY domestic | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Amos Wilson | | 14. MOTHER'S MAIDEN NAME Elizabeth Waterworth | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO ----- | | 17. INFORMANT Mrs. Marie Winchester - Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 4792X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO pneumonia and chronic pulmonary fibrosis (c) DUE TO 8 years | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) seizure | | | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour _____ am. _____ pm. _____ Jan 19 1962 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) Leonardtown, Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1 1961 to Feb 25 1962 , that (I) (we) last saw the deceased alive on Feb 25 1962 , and that death occurred on Feb 25 1962 , M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Julian S. Lane | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Julian S. Lane | | | | 22b. DATE SIGNED 2/26/62 | |
| 22c. PHYSICIAN'S NAME (Type) Julian S. Lane | | 22d. ADDRESS Bethington Park, Greenland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/28/62 | | 23c. NAME OF CEMETERY OR CREMATORIUM St. Andrews Cem. | | 23d. LOCATION (City, town, or county) (State) Leonardtown, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE FEB 28 '62 | | 25b. REGISTRAR'S SIGNATURE J. V. S. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02347

02350

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Lovetville

c. LENGTH OF STAY IN lb

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First _____

Middle _____

Last _____

4. DATE
OF
DEATH

Month February

Day 15,

Year 1962

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Long July 1, 1892

9. AGE (In years
last birthday) IF UNDER 1 YEAR

Months 69 yrs.

IF UNDER 24 HRS.
Hours Min.

Male

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Farming

Maryland

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

John Robert Long

Catherine Ann Johnson

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank & date of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Eunice A. Long Loveville, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
few min.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____
p.m. _____

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 8/31/1961 to 1961, that (I) (we) last
saw the deceased alive on 8/31/1961, and that death occurred at _____, from the causes and on the date stated above.

22a. SIGNATURE

Roy Guyther

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Roy Guyther M. D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

Mechanicsville, Maryland

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

Feb. 19, 1962

St. Joseph Cemetery

Morganza,

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

W. Clarke Mattingley Leonardtown, Maryland

DATE FEB 23 '62

Carroll & Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02348

CERTIFICATE OF DEATH

02332

1. PLACE OF DEATH
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN b.

10 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

First
Bessie

Middle
G.

Last
McWilliams

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Aug. 12, 1870

9. AGE (in years
last birthday)

91 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Home

14. MOTHER'S MAIDEN NAME

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James B. Garson

Mary E. Maddox

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank and dates of service)

No

None

George McWilliams Jr Clements, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

422.1 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stealing the underlying
cause last

(b)

DUE TO

(c)

Cerebral Thrombosis
Chronic bronchitis
Generalized Artherosclerosis

INTERVAL BETWEEN
ONSET AND DEATH
1 month

2 years

10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work

20d. INJURY OCCURRED
While at work
Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to Feb 21, 1962, that (I) (we) last saw the deceased alive on Feb. 21, 1962, and that death occurred at 8 P.M. from the causes and on the date stated above.

22e. SIGNATURE

W.H. Patrick

22c. PHYSICIAN'S
NAME (Type)

William H. Patrick M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
2-22-62

22d. ADDRESS

Lexington Park, Maryland

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial 2/24/62

23b. DATE THEREOF

Sacred Heart Cemetery

23d. LOCATION (City, town or county)

Bushwood,

(State)

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

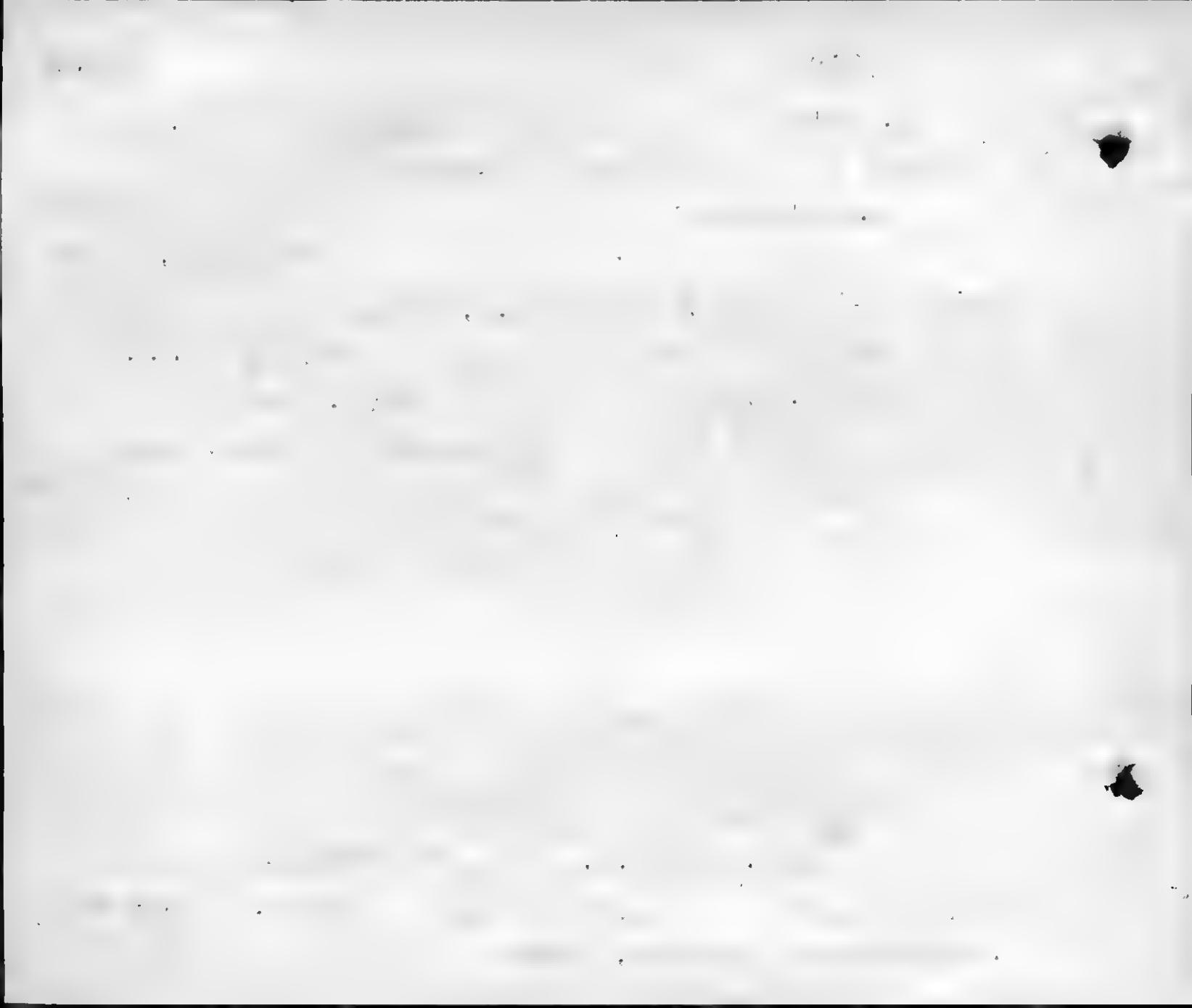
W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR

FEB 27 '62

25b. REGISTRAR'S SIGNATURE

C. L. Kline



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02333

1. PLACE OF DEATH

a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN lb

2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street name)

St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month Day Year
February 28, 1962

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

Aug. 16, 1878

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

House wife

Home

Washington, D.C.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

William Franklin Norris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Alice Dyer

Address

Lloyd E. Norris Scotland, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

(d)

Cerebral vascular accident

INTERVAL BETWEEN
ONSET AND DEATH

48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.

Fractured legs

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell on staircase

20c. TIME OF INJURY

Month Day Year

2nd INJURY OCCURRED

20e. PLACE OF INJURY

Home, farm,

20f. CITY OR TOWN

(County)

State

Hour
7:45 p.m.

2-8 1962

White Not White
at work at work

20g. FACTORY, street, office, bldg, etc.

20h. 1102 N. E.

1102 N. E.

1102 N. E.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

3/2/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

State

Burial March 3, 1962

Trinity Cemetery

St. Mary's City, Md.

23. FUNERAL DIRECTOR

W. Clarke Mattingley Leonardtown, Maryland

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

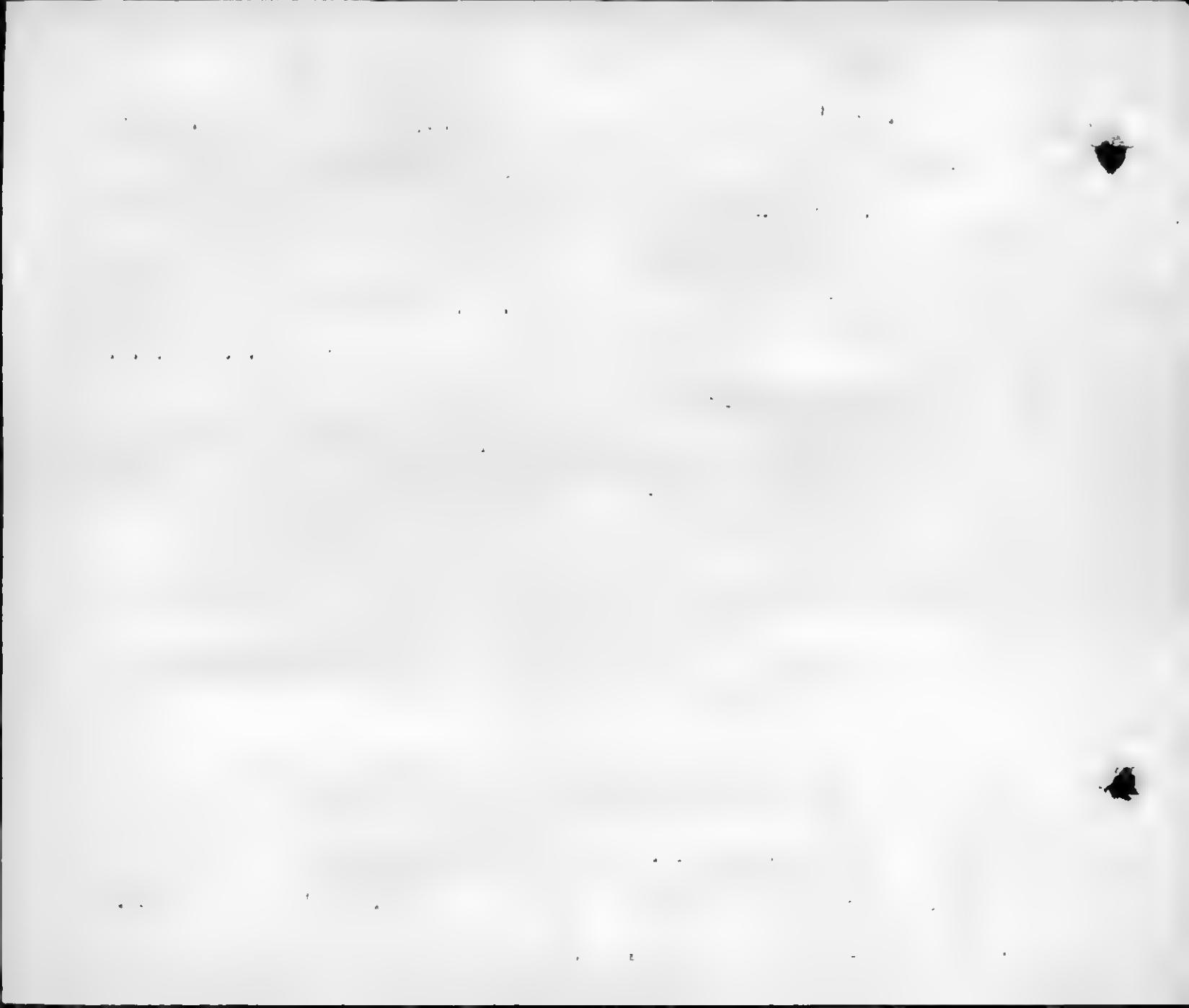
MAR 6 '62

DATE

C. May 8, 1962

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute "certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M
1
70

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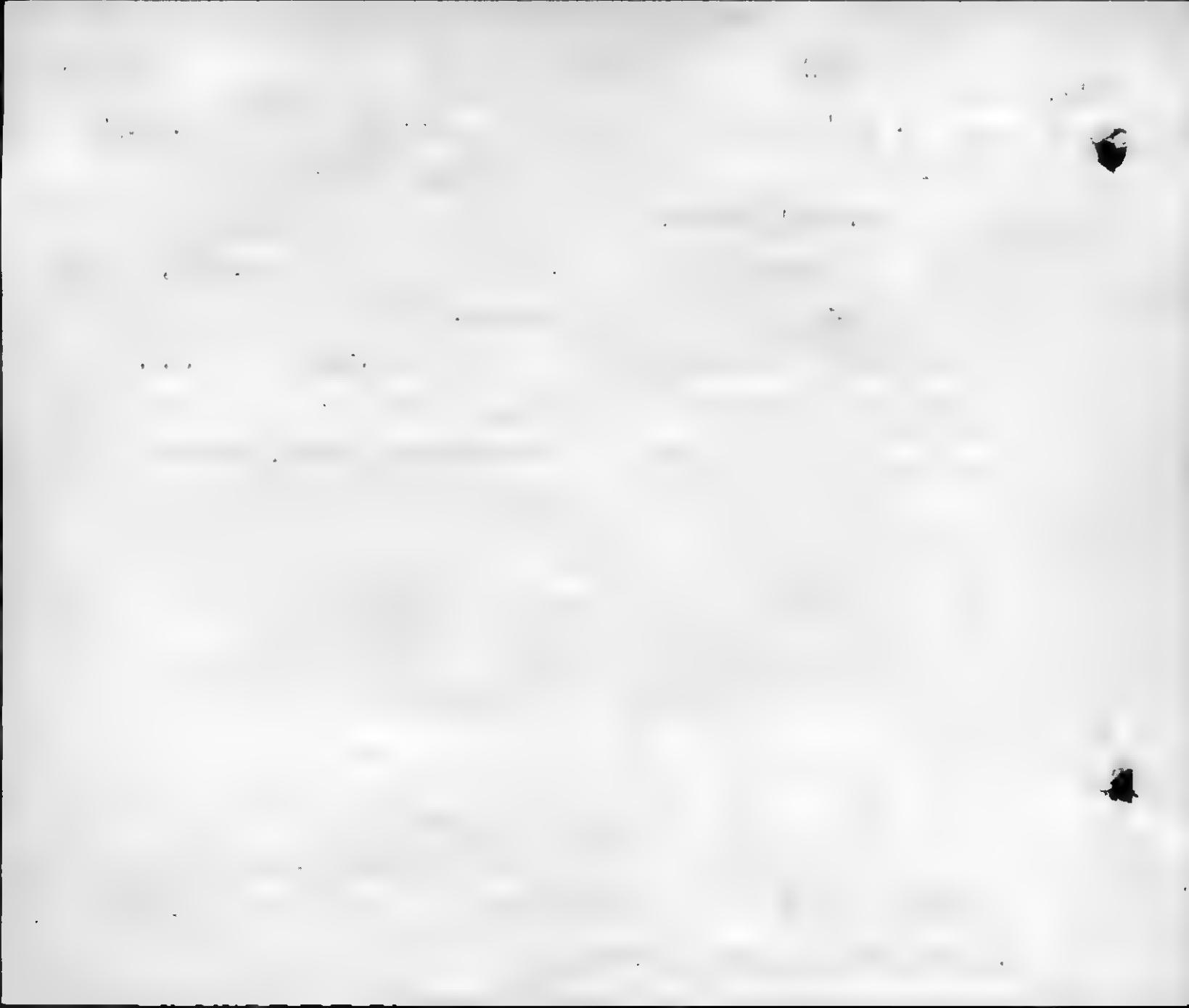
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02350

02334

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | b. COUNTY St. Mary's | |
| c. LENGTH OF STAY IN 1b 13 days | | c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Rural California | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | e. DATE OF DEATH Month Day Year February 4, 1962 | |
| f. NAME OF DECEASED (Type or print) Elizabeth Ann Pingleton | | g. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 81 yrs | |
| h. SEX Female | | i. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| j. COLOR OR RACE White | | k. DATE OF BIRTH June 24, 1880 | |
| l. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | m. KIND OF BUSINESS OR INDUSTRY Home | |
| n. BIRTHPLACE (County & State, or foreign country) Virginia | | o. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| p. FATHER'S NAME Bedford Clark | | q. MOTHER'S MAIDEN NAME Rebecca Grant | |
| r. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give rank or dates of service) No | | s. SOCIAL SECURITY NO. none | |
| t. INFORMANT (Yes, no, or unknown) (If yes give rank or dates of service) | | u. ADDRESS Joseph Pingleton Abell, Maryland | |
| v. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic CV disease | | w. INTERVAL BETWEEN ONSET AND DEATH | |
| x. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | y. DUE TO (c) | |
| z. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Bronchopneumonia | | | |
| aa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> bb. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None | | cc. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| dd. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | ee. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| ff. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | | gg. (City or town) None | |
| hh. (County) None | | ii. (State) None | |
| jj. I certify that (I) (this hospital) attended the deceased from 6/1/1961 to 2/4/1962, that (I) (we) last saw the deceased alive on 1967, and that death occurred at M, from the causes and on the date stated above. | | kk. SIGNATURE John Mattingley | |
| ll. PHYSICIAN'S NAME (Type) John Mattingley | | mm. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| nn. BURIAL, CREMATION, REMOVAL (Specify) Burial | | oo. DATE THEREOF 2/7/62 | |
| pp. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | qq. NAME OF CEMETERY OR CREMATORIAL ADDRESS Joy Chapel Cemetery | |
| rr. LOCATION (City, town or county) Hollywood, Maryland | | ss. REC'D BY REGISTRAR FEB 13 '62 | |
| tt. (State) None | | uu. REGISTRAR'S SIGNATURE Arthur S. Krause | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02351

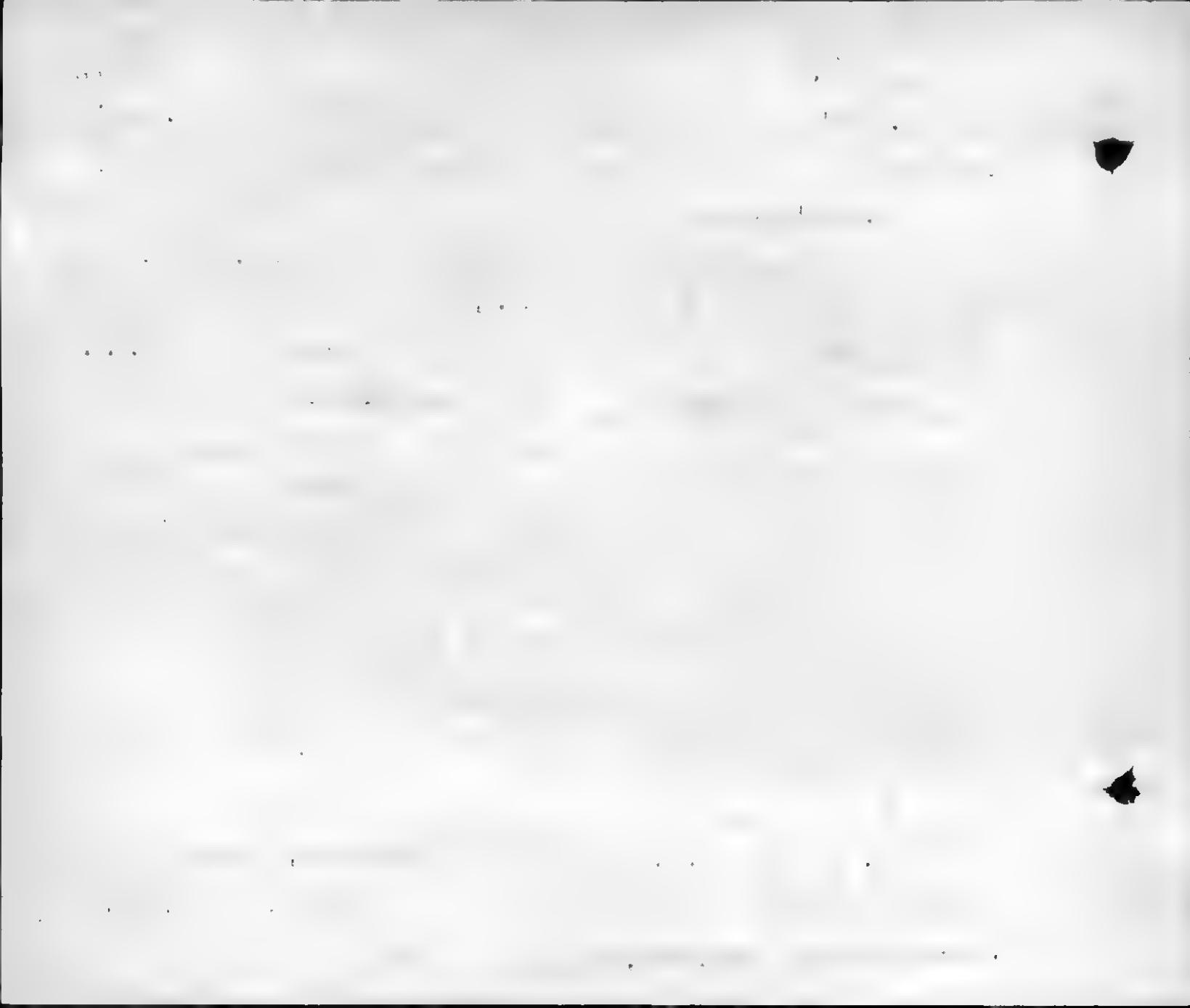
02335

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) | |
| St. Mary's | | a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | b. COUNTY St. Mary's | |
| Leonardtown | | c. LENGTH OF STAY IN lb | |
| 1 hr | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. STREET ADDRESS | |
| St. Mary's Hospital | | Rural Maddox | |
| First Middle | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) | | e. DATE OF DEATH | |
| Cora | | Feb. 22, 1962 | |
| 5 SEX | | f. AGE (In years IF UNDER 1 YEAR last birthday) Months Days Hours Min. | |
| Female White | | g. B. DATE OF BIRTH Oct. 4, 1875 | |
| h. COLOR OR RACE | | h. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| i. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | i. 10b. KIND OF BUSINESS OR INDUSTRY | |
| House wife | | j. 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| k. 13. FATHER'S NAME Richard Woodburn | | l. 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| m. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service) | | n. 16. SOCIAL SECURITY NO. 17. INFORMANT | |
| | | o. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Pneumonia, Typhosic | |
| 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), leaving the underlying cause last. | | Arteriosclerotic circumscribed, cardiac decompen.sation | |
| (b) | | INTERVAL BETWEEN ONSET AND DEATH 2 d. | |
| DUE TO cause last. | | 10 yrs | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Rhabdomyolysis</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Jan 1, 1962 to Feb 22, 1962, that (I) (we) last saw the deceased alive on Feb 22, 1962, and that death occurred at M, from the causes and on the date stated above. | | 22a. SIGNATURE <i>J. Roy Guyther</i> | |
| 22c. PHYSICIAN'S NAME (Type) J. ROY GUYTHER M. D. | | ATTENDING PHYS. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22d. ADDRESS Mechanicsville, Maryland | |
| 23b. DATE THEREOF 2/26/62 | | 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sacred Heart | |
| 23d. LOCATION (City, town or county) Bushwood, Md. | | 25a. REC'D BY REGISTRAR FEB 27 '62 | |
| 24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | 25b. REGISTRAR'S SIGNATURE <i>Clayton & Thomas</i> | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

CO-FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 3 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61



FOR STATE
HEALTH DEPT.

please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director.

Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

02352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland St. Mary's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lexington Park Unknown | | c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, USNAS | |
| 3. NAME OF DECEASED (Type or print) MARY | | First | Middle |
| | | Last | |
| 4. DATE OF DEATH February 8 | | Month | Day |
| | | Year 19 62 | |
| 5. SEX Female | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 9. DATE OF BIRTH 14 March 1924 | |
| 10a. KIND OF BUSINESS OR INDUSTRY Restaurant | | 10b. BIRTHPLACE (State or foreign country) New York | |
| 11. CITIZEN OF WHAT COUNTRY? U.S.A. | | 12. MOTHER'S MAIDEN NAME Mary Murphy | |
| 13. FATHER'S NAME Edward Clark | | 14. Address St. Mary's County Sheriff, Maryland | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Hospital Records | |
| 17. INFORMANT Acute Alcoholism | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Arlington (County) Virginia (State) 2/8/62 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D. | |
| 22e. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/13/62 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National | | 22d. LOCATION (City, town, or county) Arlington, Virginia (State) | |
| 23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | 24a. REC'D BY REGISTRAR Office of the Clerk DATE FEB 13 '62 24b. REGISTRAR'S SIGNATURE Charles S. Petty | |

100% *luteola*

100% *luteola*

100% *luteola*

0% *luteola*

0% *luteola*

80% *luteola*

80% *luteola*

80% *luteola*

80% *luteola*

80% *luteola*

0% *luteola*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02338

| | | | | | | | | | |
|---|--|--|---|--|---|---|-----------------------|------------------|---------|
| 1. PLACE OF DEATH a. COUNTY | | St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | d. STATE Maryland | | b. COUNTY St. Mary's | | | |
| Rural Colton Point | | Life | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First George | Middle Roland | Last Woodland | 4. DATE OF DEATH February 12, 1962 | Month | Day | Year | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Feb. 22, 1915 | 9. AGE (in years from birthday) 46 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George Francis Young | | 14. MOTHER'S MAIDEN NAME Mary Ella Woodland | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Ella Woodland | | Address Colton Point, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary infarct INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | | | | | | | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Severe scoliosis (Thorasic) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE | | <i>William D. Boyd</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2/12/62 | | | |
| EXAMINER'S NAME (Type) | | William D. Boyd M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/14/62 | | 22c. NAME OF CEMETERY OR CREMATORIALy Sacred Heart Cemetery | | 22d. LOCATION (City, town, or county) Bushwood, | | (State) Maryland | |
| | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | |
| W. Clarke Mattingley | | Leonardtown, Maryland | | FEB 14 '62 | | <i>C. J. Mattingley</i> | | | |
| | | | | | | | | | |

MISSOURI STATE POLICE
MOTOR EXAMINEE CERTIFICATE

| | | |
|----------------------|--------------------|----------------------|
| NAME | ADDRESS | EXAMINER |
| JOHN D. SMITH | 1234 FAIRFIELD DR. | Sgt. JAMES H. COOPER |
| AGE | SEX | GRADE |
| 35 | M | 100% |
| EDUCATION | EMPLOYMENT | DRIVING RECORD |
| 12 GRADES | TELEGRAMS | EXCELLENT |
| EXAMINER'S SIGNATURE | DATE | |
| JAMES H. COOPER | APRIL 1965 | |